



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

USMD HOSPITAL AT ARLINGTON
801 WEST I-20
ARLINGTON TX 76017

Respondent Name

AMERICAN MANUFACTURERS MUT INS

Carrier's Austin Representative Box

Box Number 21

MFDR Tracking Number

M4-07-5836-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Implants were not paid."

Amount in Dispute: \$21,570.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position summary in the response packet.

Response Submitted by: Robert F. Josey, Hanna & Plaut, L.L.P., 106 East Sixth Street, Suite 600, Austin, TX 78701

SUMMARY OF FINDINGS

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|--------------------|-------------------------------------|-------------------|-------------|
| August 24, 2006 | Implantables for Outpatient Surgery | \$21,570.00 | \$21,570.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines
4. This request for medical fee dispute resolution was received by the Division on May 9, 2007.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 45-Charges exceed your contracted/legislated fee arrangement.

- 45-Charges exceed your contracted/legislated fee arrangement. S01 Pursuant to Texas Labor Code 413.011 and other applicable statutes this bill has been reviewed to a standard of reasonableness based on current industry benchmarks of typical reimbursement for comparable services in your geographical area.
- 45-Charges exceed your contracted/legislated fee arrangement. S04 This item is packaged or bundled into another basic service or surgical procedure fee performed on this date of service, additional reimbursement disallowed.
- 45-Charges exceed your contracted/legislated fee arrangement. S11-Please provide proof of acquisition costs from the vendor.
- 45-Charges exceed your contracted/legislated fee arrangement. S31-Reimbursement for this service has been limited to a two day inpatient stay per diem.
- 45-Charges exceed your contracted/legislated fee arrangement. The charges have been reviewed by FairPay Solutions Inc.
- 113-011-Other import re-pricing completed by FairPay.
- 113-031-Export/import re-pricing explanation 1: S01-Pursuant to Texas Labor Code 413.011 and other applicable statutes this bill has been reviewed to a standard of reasonableness based on current industry benchmarks of typical reimbursement for comparable services in your geographical area.
- 113-031-Export/import re-pricing explanation 1: S04-This item is packaged or bundled into another basic service or surgical procedure fee performed on this date of service, additional reimbursement disallowed.
- 113-031-Export/import re-pricing explanation 1: S11-Please provide proof of acquisition of costs from the vendor.
- 113-031-Export/import re-pricing explanation 1: S31-Reimbursement for this service has been limited to a two day inpatient stay per diem.
- 113-035-Export/import re-pricing explanation 5: The charges have been reviewed by FairPay Solutions Inc.
- 113-Any other reductions was determined by the external vendor.

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with the Focus network. The network reduction amount on the submitted explanation of benefits dated September 26, 2006 and January 3, 2007, denotes a \$0.00. The respondent did not clarify or otherwise address the "45" claim adjustment code upon receipt of the request for dispute resolution, nor was documentation provided to support that there is a contract between the provider and Focus network. For these reasons, the Division finds that the "45" claim adjustment code is not supported.
2. Review of the submitted documentation finds that the carrier denied payment for the implantables with explanation code "S11-Please provide proof of acquisition costs from the vendor," which directed the requestor to provide invoices for review of these charges. Upon reconsideration, the requestor provided a Medtronic invoice for the items billed under revenue code 278 for \$21,570.00. The respondent maintained their denial of "S11" and paid \$0.00 for the implantables.
3. The disputed services were provided on August 24, 2006 in a hospital outpatient setting based on the Requestor's medical billing showing services only for one day for twelve hours. The Division did not have a specific medical fee guideline for outpatient hospital services until its rule at 28 Texas Administrative Code §134.403 was adopted, effective March 1, 2008. Therefore, the 'fair and reasonable' fee guideline provisions in 28 Texas Administrative Code §134.1 were effective as specified in the adoption rule preamble in Bolume 31 of the *Texas Register* beginning on page 3561.
4. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of

reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:

- The requestor’s rationale for increased reimbursement from the *Table of Disputed Services* asserts that “Implants were not paid.”
- The requestor submitted a copy of a Medtronic Invoice with the claimant’s name on it for implantables at a cost to the provider of \$21,570.00.
- Review of the submitted documentation finds that the requestor is asking for reimbursement of the cost of the implantables at \$21,570.00. The respondent paid \$0.00. The Division concludes that the amount of \$21,570.00 is fair and reasonable reimbursement for the implantables.

The request for additional reimbursement is supported. Thorough review of the submitted documentation finds that the requestor has discussed, demonstrated, and justified that the amount sought is fair and reasonable.

7. 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(II), effective December 31, 2006, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, requires the respondent to provide “a position statement of reasons why the disputed medical fees should not be paid.” Review of the submitted documentation finds that the respondent has not provided a position statement of reasons why the disputed medical fees should not be paid. The Division concludes that the respondent has not met the requirements of §133.307(d)(2)(A)(iv)(II).
8. 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(III), effective December 31, 2006, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, requires the respondent to provide a statement of the disputed fee issue(s), which includes: “a discussion of how the Labor Code and Division rules, including fee guidelines, impact the disputed fee issues.” Review of the submitted documentation finds that the respondent has not discussed how the Labor Code and Division rules, including fee guidelines, impact the disputed fee issues. The Division concludes that the respondent has not met the requirements of §133.307(d)(2)(A)(iv)(III).
9. 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(IV), effective December 31, 2006, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, requires the respondent to provide a statement of the disputed fee issue(s), which includes: “a discussion regarding how the submitted documentation supports the respondent’s position for each disputed fee issue.” Review of the documentation finds that the respondent did not submit any documentation that discussed the respondent’s position for each disputed fee issue or how no payment for the disputed services, i.e. the implantables specified in the medical billing, constituted a “fair and reasonable” payment amount in accordance with 28 Texas Administrative Code §134.1 in effect on the service date in question. The Division concludes that the respondent has not met the requirements of §133.307(d)(2)(A)(iv)(IV).
10. 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(V), effective December 31, 2006, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, requires the respondent to provide “documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 of this title if the dispute involves health care for which the Division has not established a MAR, as applicable.” Review of the submitted documentation finds that:
 - The respondent did not submit a position statement.
 - The respondent did not submit documentation to support that payment of \$0.00 for the implantables is fair and reasonable.
 - The respondent did not discuss or explain how the \$0.00 represents a fair and reasonable reimbursement for the services in dispute.
 - The respondent did not submit documentation to support that \$0.00 is a fair and reasonable rate of reimbursement for the disputed services.
 - The respondent did not explain how \$0.00 satisfies the requirements of 28 Texas Administrative Code §134.1.

The respondent’s position is not supported. Thorough review of the submitted documentation finds that the respondent has not demonstrated or justified that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute. The Division concludes that the respondent has not met the requirements of 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(V).

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the requestor has established that additional reimbursement is due. The Division concludes that the carrier's response was not submitted in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the respondent failed to support that the amount paid by the insurance carrier is a fair and reasonable reimbursement in accordance with Division rule at 28 Texas Administrative Code §134.1. As a result, the amount ordered is \$21,570.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

| | | |
|--------------------|---|-----------------------------|
| _____ Signature | _____ Medical Fee Dispute Resolution Officer | _____ 10/28/2011 Date |
|--------------------|---|-----------------------------|

| | | |
|--------------------|---|-----------------------------|
| _____ Signature | _____ Medical Fee Dispute Resolution Manager | _____ 10/28/2011 Date |
|--------------------|---|-----------------------------|

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.